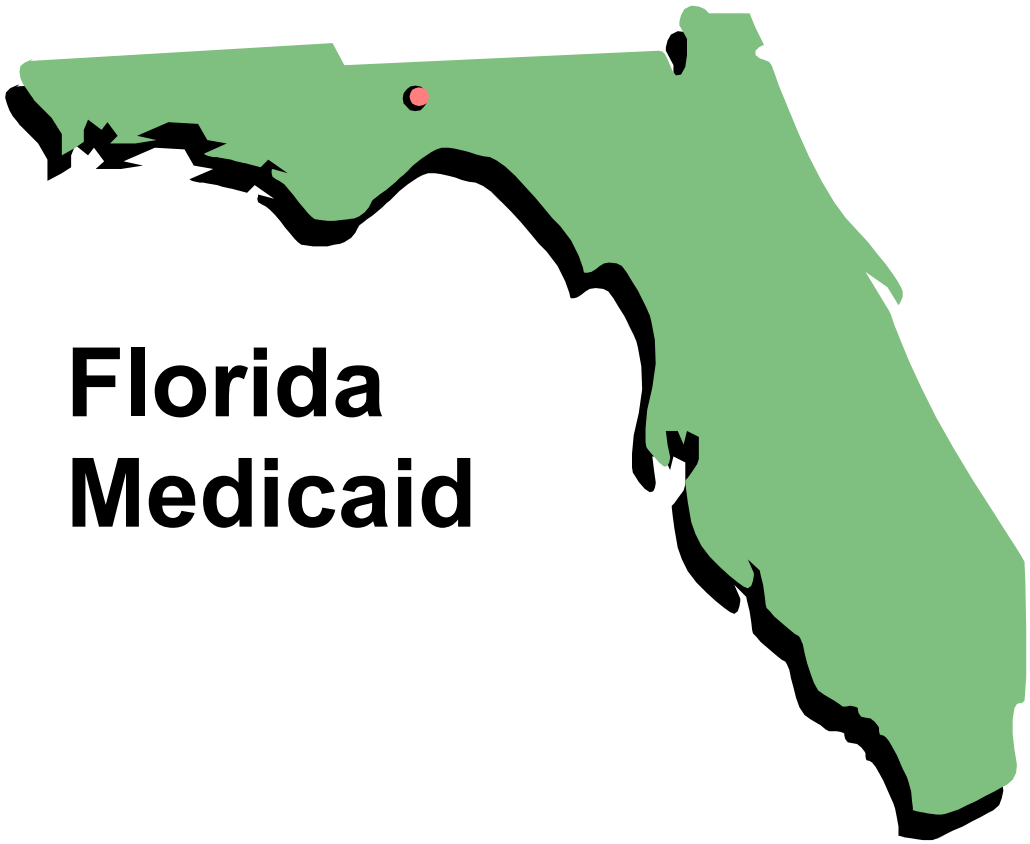

Florida Medicaid

Durable Medical Equipment and Medical Supply Services Coverage Policy: Respiratory

Agency for Health Care Administration

December 2023

Rule 59G-4.074
Effective December 2023

Table of Contents

1.0 Introduction

Florida Medicaid respiratory durable medical equipment and medical supply (DME) services provide medically necessary equipment or supplies to eligible recipients for the care and treatment of pulmonary insufficiencies.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render respiratory DME services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) website at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid DME services are authorized by the following:

- Title XIX of the Social Security Act (SSA) Section 1902
- Title 42, Code of Federal Regulations (CFR) Part 440
- Section 409.906, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to Florida Medicaid's Definitions Policy.

1.4.1 Certificate of Medicaid Necessity (CMN)

Documentation signed by the ordering practitioner to establish a recipient's need for certain durable medical equipment. The CMN states the recipient's diagnosis, prognosis, reason for the equipment, and estimated duration of need.

1.4.2 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.3 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.5 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.6 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.7 Qualified Technician
A working provider or a provider's employee who is able to demonstrate the appropriate level of training and competency necessary to perform DME equipment repairs and maintenance. A qualified technician may not substitute for a required licensed professional.

1.4.8 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary respiratory DME services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments
There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid respiratory DME services.

3.2 Who Can Provide
Services must be rendered by one of the following:

- Durable medical equipment and supply services businesses fully licensed as Home Medical Equipment providers in accordance with Chapter 400, F.S.
- Medical oxygen retail establishments fully permitted in accordance with Chapter 499, F.S. that employ or contract with the following providers, who have completed in-home oxygen equipment and pulse oximeter set ups and trainings:
  - Registered nurses licensed in accordance with Chapter 464, F.S.
  - Respiratory care practitioners
  - Respiratory therapists licensed in accordance with Chapter 468, F.S.
- Pharmacies fully licensed in accordance with Chapter 465, F.S.

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria
Florida Medicaid covers respiratory DME services in accordance with the American Medical Association's Current Procedural Terminology (CPT) and Healthcare Common Procedure

Coding System (HCPCS), and the applicable Florida Medicaid fee schedule(s), or as specified in this policy.

Florida Medicaid covers custom and specialized equipment when a less costly alternative is not available to fulfill the recipient's need.

Florida Medicaid-covered DME must include a manufacturer's or one-year warranty, whichever is greater.

4.2.1 Oxygen and Oxygen-Related Equipment

Florida Medicaid covers stationary and portable oxygen modalities and oxygen-related equipment, including:

- Compressed oxygen systems
- Concentrators
- Liquid oxygen systems
  - Setup and delivery supervised by a licensed professional
  - The oxygen provider must be able to provide recipients with emergency service. Emergency service includes:
    - Responding to an oxygen failure within two hours or less
    - Having appropriate staff available twenty-four (24) hours a day, seven (7) days a week
    - Providing an emergency supply that will last the duration of the emergency, including services provided during the aftermath of a natural or national disaster
    - Ensuring oxygen and oxygen-related equipment is set up in the recipient's home, a licensed certified respiratory therapist (CRT), registered respiratory therapist (RRT), registered nurse (RN), or respiratory care practitioner (RCP) who is employed by or under a current contract agreement with the DME provider supervises the placement and set up of the equipment in the recipient's home
    - Ensuring recipient home visits are performed by qualified individuals at the frequency required by policy for the service or device provided
    - Ensuring that oxygen and oxygen-related equipment is delivered by the appropriately trained staff in the recipient's home and residence

4.2.2 Ventilators and Respiratory-Assist Devices

4.2.2.1 Continuous Positive Airway Pressure Devices (CPAP) and Bi-Level Positive Airway Pressure Devices (BIPAP)

Florida Medicaid covers CPAP and BIPAP devices for recipients who have completed a sleep study, within 30 days of the prescription of the device.

- A recipient must first have unsuccessful results from use of a CPAP before becoming eligible to receive a BIPAP device.
- Heated or non-heated humidifiers prescribed for use with the covered CPAP or BIPAP device are not included in the device's monthly rental fee and may be reimbursed separately if the humidifier is not integral to the CPAP or BIPAP device itself.

4.2.2.2 Ventilators

Florida Medicaid covers the following types of ventilators that include back-up ventilators:

- Alternating positive airway pressure
  - Reimbursement includes all connectors, pressure measuring and alarm devices, breathing circuits, in-line thermometers, water traps, adapters, and training by licensed professionals.
- Intermittent positive pressure breathing machines (IPPB)

- Positive or negative pressure volume ventilators

4.2.2.3 Apnea Monitors

Florida Medicaid covers apnea monitors with or without recording features for recipients under the age of 21 years.

The provider must ensure that the following equipment is available at the time of delivery and set-up:

- Battery pack, case, and emergency battery
- Two sets of electrodes
  - If disposable electrodes are necessary, at least ninety per month
- Two sets of modified safety lead wires.
- Two electrode belts
- Operator's manual
  - If necessary, a copy of the infant monitoring handbook.
- Remote alarm, if prescribed

4.2.2.4 Nebulizers

Florida Medicaid covers nebulizers that include administration kits that include the following:

- Hand-held mouthpiece
- Lid, jar, and baffles
- Tubing
- T-piece

Providers may store nebulizers at physicians' offices for distribution, in accordance with section 409.912, F.S.

4.2.3 Respiratory Equipment

Florida Medicaid covers the following respiratory equipment:

- Compressors
  - Medicaid covers an air powered source compressor when it is:
    - Used to support medical equipment that is not self-contained
    - Used with a nebulizer that provides at least 50 pounds per square inch (psi)
- Peak flow meters
  - Providers must train the recipient and caregiver in the proper use of the device at time of pick-up or delivery.
- Pulse oximeters
  - At a minimum, aquarterly visit must be made by a qualified technician to ensure the device is functioning properly and being used appropriately
- Resuscitator bags for recipient-owned ventilators
- Tracheostomy supplies

4.2.4 Maintenance and Repair

Florida Medicaid covers maintenance and repairs of respiratory DME that meets all of the following criteria:

- Equipment damage is not due to misuse, neglect or wrongful disposition by the recipient, caregiver, or provider
- Equipment warranty is expired or does not cover the necessary maintenance or repairs
- Florida Medicaid provided the equipment

4.2.5 Used and Refurbished Equipment

Florida Medicaid covers used and refurbished respiratory DME that meets all of the following criteria:

- Equipment records indicate that the item is functional, sanitized, and serviced prior to delivery
- Equipment and replaced parts are the equivalent in quality and condition to the manufacturer's warranty on a new item
- Equipment must be durable enough to meet Florida Medicaid's maximum limit replacement requirements as stated on the DME fee schedule incorporated by reference in Rule 59G-4.002, F.A.C.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following as part of this service benefit:

- Accessory items billed separately from respiratory durable medical equipment
- Respiratory DME or medical supplies provided to recipients ages 21 and over residing in institutional settings (e.g., skilled nursing facilities)
- Items listed or identified in a procedure code's description that are billed separately
- Nebulizers supplied from a physician's office who has a financial interest in the provider
- Personal comfort, convenience, hygiene, or general sanitation items
- Pick-up, delivery, set up, and training, separately
- Repairs and maintenance of rental equipment, separately
- Replacement parts, repairs, or labor for equipment within the warranty period
- Resuscitator bags reimbursed separately from ventilator rentals
- Shipping, handling, labor, measuring, fitting, or adjusting, separately
- Simultaneous delivery of multiple types of oxygen
- Travel time and repair assessment time
- Unsupervised set up of oxygen and oxygen-related services by unlicensed provider staff

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Policy.

6.2 Specific Criteria

Providers must maintain the following documentation in the recipient's file:

- Equipment and supply delivery, pick-up, and return documentation as specified in section 400.94, F.S.

- Florida Medicaid-covered DME must include manufacturer's or one-year warranty, whichever is greater
- Recipient training documentation
- Rental equipment maintenance and repairs
- Used equipment documentation, including a signed agreement with recipient, acknowledging receipt of used equipment

Providers must also maintain one of the following in the recipient's file:

- Certificate of Medical Necessity, prepared and signed by the authorizing practitioner, that meets all of the following requirements:
  - Is dated within 21 days after the initiation of service
  - Is less than 12 months old
  - Specifies a diagnosis as the basis for the services prescribed
- Current hospital discharge plan, when applicable, that clearly describes the type of DME item or service ordered
- Written prescription
  - Is less than 12 months old
  - Is dated within 21 days after the initiation of services
  - When applicable, documentation for redetermination of medical necessity or reauthorization of services

The plan of care, when applicable, must be individualized and specify all of the following:

- Frequency of use
- Length of time the recipient requires DME
- Quantity
- Type of DME

6.2.1 Oxygen and Oxygen-Related Equipment Criteria

Providers must maintain the following documentation in addition to the criteria specified in section 6.2:

- For portable oxygen, a list of recommended exercises or activities that cannot be accomplished with the use of stationary oxygen
- Number of hours of use per quarter for concentrators, when applicable
- Set-up and quarterly visit records
- Test results specifying blood oxygen levels
- Providers must ensure that recipients have valid prescriptions for oxygen services (prescriptions must be filled within 30 days). Recipients must receive an additional examination and a new prescription for oxygen services if a prescription for oxygen services has not been filled within 30 days of the prescribing date.
- Providers must ensure that recipients receiving oxygen services obtain medical necessity renewals from their treating practitioner once every 12 months.

6.2.2 Ventilators, Respiratory Equipment and Respiratory-Assist Devices Criteria

Providers must maintain the following documentation in addition to the criteria specified in section 6.2:

- Equipment assessment records
- Home care protocol for ventilators and alternating positive airway pressure and intermittent positive ventilation systems
- Manufacturer's name, model, and serial number of recipient-owned ventilators that receive repairs covered by Medicaid
- Oxygen requirements for ventilators and alternating positive airway pressure and intermittent positive ventilation systems
- Quarterly assessments for IPPB machines and ventilators

- Sleep study reports signed and dated by a physician licensed in accordance with Chapters 458 or 459, F.S. for CPAP and BIPAP machines
- Apnea event recordings by apnea monitors
- Records of home visits from licensed or qualified registered providers that must occur within five days of the recipient's discharge and then once every 30 days during the use of apnea monitors
- Treatment plans for peak flow meters

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

Providers must obtain authorization from the quality improvement organization (QIO) as follows:

- For miscellaneous procedure codes
- When indicated on the applicable Florida Medicaid fee schedule(s)

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

Providers must include a non-classified procedure code for customized equipment on the claim form.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's website at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 By-Report Claims

By-report claims involve non-classified procedure codes as indicated on the DME fee schedule incorporated by reference in Rule 59G-4.002, F.A.C., and require medical reviews by the QIO to approve and price the DME service.

Providers must submit all of the following to the Florida Medicaid QIO:

- Description of the items or services provided, including manufacturer's information
- Documentation of medical necessity
- Documentation of the provider's costs incurred, including invoices
- Documentation of the warranty and before and after descriptions of the item for repairs

8.5.2 Maintenance and Repair

Florida Medicaid reimburses up to 75% of the equipment's original cost.

8.5.3 Rental Equipment

Florida Medicaid reimburses for rental equipment at the prorated daily amount of the monthly rate, per day, when the item is returned to the provider before the end of a 30-day period.

Florida Medicaid reimburses for up to the total of ten monthly claims for rent-to-purchase items; the item(s) then becomes the personal property of the recipient at the end of the lease.

8.5.3.1 Bundled Services

Florida Medicaid's rental amount for the following respiratory DME includes reimbursement for all supplies and replacements needed to operate devices during the full rental period:

- Alternating Positive Airway Pressure and Intermittent Positive Ventilation Systems
- Apnea monitors
- CPAP and BIPAP devices
- IPPB machines
- Positive or negative pressure volume ventilators
  - Rental amount includes resuscitator bags

8.5.4 Oxygen and Oxygen-Related Equipment

Florida Medicaid reimburses for oxygen equipment delivered to a recipient's home up to 72 hours prior to the recipient's discharge from a hospital or skilled nursing facility.

Florida Medicaid reimburses for only one form of oxygen (gaseous, liquid, or concentrated) at a time.

Florida Medicaid reimburses for servicing recipient-owned oxygen equipment.

8.5.5 Used and Refurbished Equipment

Florida Medicaid reimburses for used equipment at the lesser of 66% of:

- The provider's usual and customary fee for new equipment
- The maximum rate on the applicable fee schedule

Florida Medicaid reimburses for refurbished equipment at 100% of the maximum rental fee on the applicable fee schedule.